

Self-Supervision for Therapists

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It's great if you have a supervisor available but sometimes there is a case you need help on before supervision. And sometimes you don't have a supervisor. So, what's a therapist to do?

Today we'll look at several strategies for self-supervision and then we'll take a look at some of the most common errors that can interfere with your work.

First of all, videotape your work. That way you can study your session in detail and get the help you need. Then watch your videotapes. But what should we watch for? I remember watching my first videotapes and I would be just as confused after watching it as I had been before. Why? I didn't know what to look for. I didn't know how to analyze the videotape. I didn't know how to assess whether my interventions had been helpful or not.

Let's start with a checklist that will help you sort out potential problems in a hurry:

- 1) At the beginning of your session is there an internal problem the patient has declared? A lot of times, your problem is right there. If you come from an approach where you just listened to whatever the patient says, this whole idea of getting an internal problem to work on is new. If the patient didn't declare an internal problem to work on, in your next session ask what problem the patient wants to work on. If you still don't get a problem

declared, look at the next videotape and label the defenses the patient uses to avoid declaring an internal problem. Then in your next session focus again on the problem while helping the patient see the ways he avoids declaring a problem and, thus, depending on you.

- 2) Once the patient has declared a problem, has he declared his will to work on it? If not, look at the video and label the defenses the patient uses to avoid declaring his will to look at the problem. If the patient declared his will on the video, look to see whether anxiety and defenses rise. For instance, if the patient declares his will but he doesn't sigh, will is not online. Start looking for the defenses the patient uses to avoid declaring his will. For instance, does he wait passively to follow your will? Does he take a defiant stance, as if he has to ward off your will? If so, deactivate those projections of will onto you so he can own his will to work on his problem.
- 3) Has the patient declared a specific example of the problem? If not, look at the video and label the defenses the patient uses to avoid declaring a specific example. Then address those defenses in the next session until you get a specific example.
- 4) If all those elements of the checklist are in place, then we need to go the following series of steps to analyze your tape and figure out where the problems lie.

- 5) If the patient has declared a problem, his will to work on a specific problem, and a specific example, you are now exploring the patient's feelings. If you are getting stuck, analyze each patient response. Is it feeling, anxiety or defense? In your next session, identify each defense and return to a focus on feelings.
- 6) If that focus didn't work, examine each patient response. Was the patient's response a defense against feeling or a defense against contact--- emotional closeness with the therapist? If exploring feelings yielded no sighing or tension, most likely, the patient is warding off closeness with you. In the next session, note the ways the patient distances from you by going silent, withdrawing, going passive, hesitating, detaching, or going helpless. Note how these defenses avoid emotional closeness with you. Then ask for the feelings toward you. Why? Because the patient is warding off closeness with you. Until this barrier drops, you won't be able to access feelings in other relationships.

Now, focusing on our videos is hard. So let's take a look at the guidelines for examining your video. First of all, do NOT focus much on your interventions. Focus only on the patient's responses. Only by focusing on patient responses will we learn what the patient needs. Don't focus on what you said; focus on the patient's response. We make mistakes because we can't assess the patient's responses. Forget about your

interventions. If you focus on them too much, you'll probably just judge yourself and be afraid to look at the tape. You never have to fear the video; you are fearing your internal judgment. So, focus only on patient responses.

To start, focus on just five or ten minutes of tape. When we have a problem with a patient, we have the same problem throughout the entire video. Rather than look at the entire video, closely examine just five or ten minutes of the video in detail. Assess each patient response: was it feeling, anxiety or defense? If it was feeling, did you explore feeling? If anxiety was too high, did you regulate anxiety and then explore feeling? If it was defense, did you block the defense by asking for feeling again or did you label the defense and ask for feeling again? If you did those things, go to the next paragraph.

You are exploring a feeling in a current or past relationship and the therapy is stuck. Look at each patient response and ask yourself: did the patient's response bring us into closer emotional contact or did the patient's response make us more distant.

These patient responses tell you that the patient is resisting emotional closeness with you.

So here's **step one**. When watching a videotape, transcribe it. Then (here's the important step one), analyze each patient statement. Was it a stimulus, an expression of feeling, an example of excessive anxiety, or was it a defense?

Here's **step two**: analyze each of your interventions. Did you ask for feeling, regulate anxiety, or help the patient see and let go of a defense? When I was first learning ISTDP, I learned that many of my interventions were NOT asking for feeling, regulating anxiety, or helping the patient see and let go of a defense. Many of my interventions were just reflections or intellectualizations. That was a big surprise to me. See what the proportion is between your exploring feelings or cognizing. See if next time you can reduce the number of reflections and increase the number of times you explore feelings.

Step three: compare the patient's responses and your interventions. When the patient expressed a feeling, did you explore it? If the patient's anxiety was too high, did you regulate it? When the patient used a defense, did you address the defense? In other words, did your intervention address the patient's response and need? Often, we find a pattern in our work. We fail to explore a patient's feeling. Or we tend to intellectualize rather than address a defense. When you see your pattern, you can focus more easily in the next session.

When you address a defense do you remember to ask the patient about the feeling? Always remember to do that one two punch. Reduce resistance and mobilize the unconscious. If you address only defense but don't ask about feelings ("Do you notice how you cover your feelings with vagueness?"), the patient will flatten out and the process will become cognitive. So always

remember to ask about feelings (“So if we look under the vagueness, can we take a look at the feelings?”).

Another common mistake is that we bury our invitation to feeling under a barrage of intellectualization: “What’s the feeling toward him for hurting you in that way in front of your aunt’s house near the North Pole right after Christmas time?” The intervention should be: “What’s the feeling toward him?” Sometimes we bury our invitation under the stimulus: “What’s the feeling toward him for verbally abusing you in the restaurant?” The intervention should be: “He verbally abused you, so what’s the feeling toward him?” Notice how we end the intervention with the invitation to feeling? That makes the intervention clear and obvious for the patient.

Step four: when the patient uses a defense, do you address it right away? If not, speed up your tempo of intervention: intervene as soon as you know it’s a defense. The longer you let the patient use his defense, the more out of touch he becomes with his feelings and himself. When you analyze your transcript, how many defenses do you let go by before you intervene? Next time, intervene after each defense. The longer the patient uses a defense the more distant or depressed he becomes. As soon as you hear a defense, intervene. Rather than listen to four more instances of self-attack, intervene as soon as you hear self-attack. Then the patient’s symptoms will drop in session and regression will stop. Just the other day, a patient said on tape, “I think I’m stupid. It’s clear I can’t pass that test. I was such an idiot to even think I could go to college. And then I am so

ugly no girl would want to go out with me.” Four defenses in a row. Label each sentence the patient makes. If you are finding several defense sentences in a row, you have found out where you can become more effective. Interrupt after the first self-attack, not the fourth. Remember: the more defenses you watch, the more the patient will suffer.

Step five: make a list of the patient’s defenses. Identify defenses and the price so the patient can let go of them to face her feeling. Also, notice what defense comes up the most. That is the pillar defense. Focus on that one in the next session.

Step six: let’s suppose you have done all these steps and you are still puzzled. “Did I do anything worthwhile?” I’m sure you did, but most students have trouble knowing what they did that worked. Watch the tape again but with the sound OFF! Notice every time the patient sighs. The sigh is a sign of unconscious anxiety: i.e., you are doing something helpful. Next, rewind the video to find out what intervention triggered the unconscious anxiety. That was a good intervention. Make a list of every intervention that triggered anxiety. Those are your effective interventions. In the next session, use those interventions more frequently. If an intervention works, keep using it and maintain that focus.

Step seven: Okay. Let’s suppose you didn’t see any sighing. That can happen for many different reasons. Do not despair. We just need to do some assessment. For instance, the patient may be an:

1) *Involuntary referral*. The patient does not want to do therapy or share his feelings, so no feeling rises to trigger anxiety. *Solution*: accept the patient's lack of desire. Point out that you have no right to do therapy with someone who does not want it. Leave the door open for him to return later when he is in a different stage of the change process (Miller and Rollnick 2002; Prochaska and Norcross 2007).

2) *Ambivalence*. The patient has one foot in and one foot out. He does not want to be involved, so no feelings or anxiety will rise. *Solution*: Explore his ambivalence. If he does not see how his defenses hurt him, he will not see how therapy could help him. Clarify causality to reach a consensus on what causes his presenting problems.

If he says he is doing therapy to obey someone else, this is a projection. Block this projection and clarify what is an internal problem for him until you reach consensus on the task.

If he projects his will onto you, deactivate that projection until he owns his desire for therapy.

If he understands the task, but does not believe he can do it, help him see the defense of underestimating himself.

3) *Organic or brain factors*: The patient may experience genuine confusion about the therapeutic process due to brain injury, below average intelligence, or physical illness and exhaustion. *Solution*: explain the therapeutic task clearly and simply for patients with below average

intelligence to get a conscious therapeutic alliance. Do supportive psychotherapy while physically ill patients recover the strength to do an exploratory therapy.

- 4) *Discharge of anxiety into smooth muscles or cognitive/perceptual disruption.* These patients look superficially calm because their anxiety is discharged into smooth muscles and cognitive perceptual disruption instead of tension. *Solution:* regulate anxiety until it returns to the striated muscles.
- 5) *Discharge of anxiety through subtle tensing or hiding the tension consciously.* The patient can get rid of her anxiety by chewing gum, so it does not show up elsewhere in the body. *Solution:* ask the patient to take out the gum. Anxiety will appear in the body instead, becoming more obvious to the patient and more visible to the therapist. A patient who consciously hides anxiety will look stiff. His face will seem like a mask, lacking spontaneous expression. He immobilizes his body to avoid experiencing feelings in it.
- 6) *Characterological defenses hide unconscious transference feelings:* defiance, compliance, externalization, passivity, hopelessness, helplessness, high degrees of intellectualization, syntonic defenses, denial, and projection or projective identification. (See chapter in *Co-Creating Change* on tactical and repressive defenses.) Rather than experience her anger, the patient can hide it under helplessness. Unaware

of her anger, she feels no anxiety. *Solution:* help patients see their defenses and turn against them. Feelings will rise, triggering anxiety in the body.

- 7) *Repression of feelings:* depression, conversion, or suicidal plans. The defense of turning anger on the self can make the signaling of striated muscles drop. *Solution:* help the patient see and turn against the defense. Then ask about feelings toward you that the critical thoughts could be covering. Feeling and anxiety will rise.
- 8) *Errors in technique:* no unconscious anxiety will rise if the therapist: a) does not focus on feeling consistently enough; b) focuses on defenses or feelings which are not present; or c) challenges the defenses before the patient has differentiated herself from them. In this last instance, the patient will feel attacked. This misalliance will trigger conscious anger, but not unconscious anxiety.
- 9) *Activation of the transference resistance.* For instance, if a patient develops an oppositional transference resistance, and the therapist argues with her, this interactional defense will repress feelings, and the patient will feel no anxiety. If the patient adopts a passive, helpless stance, and the therapist acts out the active role of the “helper”, the patient will feel no anxiety. When the therapist enacts the transference resistance, no unconscious anxiety will rise. *Solution:* deactivate the transference

resistance. See the chapter on transference resistance in *Co-Creating Change*.

10) *Over-medication*. Patients on many medications or illegal substances appear emotionally flat. These patients show no tension, fidgeting, or shifting in the chair. If a patient appears emotionally flat, ask if he is taking any psychotropic or pain medications. *Solution*: consult with the psychiatrist to reduce medications. This sometimes helps patients become aware of their anxiety and feelings.

Let's suppose you are correctly addressing defenses against feeling and nothing is happening! I just saw a case like that the other day. The supervisee presented a patient. The supervisee addressed the patient's defense of intellectualization. Then he addressed the patient's defense of self-attack. Then he addressed how the patient detached from feelings. One after another, he did a beautiful job addressing the patient's defenses against feeling. Yet we saw no unconscious signaling of anxiety. Why? A few minutes into the tape the patient mentioned he was having a reaction to the therapist. It turned out that the patient's problem was not defenses against feeling. His problem was that he was warding off contact with the therapist.

The therapist needed to shift from addressing the patient's defenses against feeling to the defense the patient used to ward off the therapist. This is one of the most frequent problems we run into. For instance, after several minutes of defense work, if nothing is happening you can shift your focus in

defense work. Here is how you address intellectualization as a defense against feeling: “That is your thought, but your thought is not a feeling. If you don’t cover your feeling with a thought, what is the feeling toward your boss?” If the patient keeps using those defenses and remains distant, shift focus to the transference resistance. “That is your thought, but your thought is not a feeling. Do you notice how this wall of thoughts is coming up between us? What is the feeling toward me that makes you put up this wall of words?” In this step, ask yourself: is the patient avoiding sharing feelings, or is the patient avoiding contact with me? If the patient is avoiding contact with you, focus on the relationship between the two of you. Point out how the patient is maintaining some distance and start asking about the feelings toward you that lead the patient to use a barrier.

Every time a patient does NOT sigh after you ask for feelings, write down the next thing he says. Now that you have a list of ten of those statements, see what kind of defense the patient uses each time. Now you can see the system of resistance the patient is using to avoid mixed feelings. Is he using projection/splitting? Is he turning rage against himself and getting depressed? Or is he detaching from his feelings and from you?

Step eight: sometimes you are stuck with a patient and can’t figure out why. But you notice you keep feeling pulled into making the same mistakes. If you can’t figure out what is going on in the case and the analysis of the transcript is not getting anywhere, here is another thing you can do. Just watch the video and notice what you feel. That’s all. No analysis of your interventions. No

analysis of the patient. Just notice shifts in what you feel. Notice what you feel before you intervene. Notice what you sense in your body as the patient speaks. Just learning to bear what you feel and sitting with that will lead to a shift in the next session.

Often, when we are unaware of what we are feeling and sensing in our body, those sensations push us to react in habitual ways. Knowing and sensing what we feel, even if we don't yet understand those feelings, will deactivate our habitual actions, leading to more effective responsiveness.

Step nine: If you are working with a depressed patient who is not getting better, analyze each statement you make for a five minute passage of the video. Count the number of sentences you do the following: 1) invite feelings; 2) regulate anxiety; 3) point out a defense; and 4) cognizing. When depressed patients are not improving, often therapists cognize and point out defenses far more than inviting feelings. See if you can increase the number of times you invite the patient to face her feelings and decrease the number of times you talk about defenses and cognize. See what happens if you can encourage your patient to do something helpful (would like to take a look at this? Could we take a look at this feeling so we can help you overcome this depression? Wouldn't it be nice to know what you feel so you wouldn't have to have these symptoms instead? Shall we take a look at this feeling?) between 3 and nine times a minute. This increased dose of encouragement and decreased dose of discouragement (pointing out defenses---what she does wrong) should help to

move the therapy forward. Remember: there is only one reason to point out a defense---to help the patient do something healthy instead, like facing her feelings.

Step ten: often we get stuck, arguing with the patient, or more subtly asking the patient not to do what he or she is doing. That is, we are resisting the patient's resistance. And when we resist the patient's resistance, we reinforce it. What to do? Watch your video and each time the patient says something on the video, say out loud to the video, "I can accept this." As you keep doing this, you will become more aware of what you are not accepting. That is, you will become more aware of your resistance, the way you are reinforcing the patient's resistance. Go through the entire video, continually saying, "I can accept this." Notice how begin to accept the patient (meaning, reality). If you are still not accepting the patient, watch the video again, and this time each time the patient speaks, say out loud, "I don't want to accept you as you are in this moment."

The next step is to make a list of what you cannot accept in the patient. Now find three ways that each of these things are true about you. And find three ways that you reject these aspects of yourself. Once you regain a capacity to accept yourself on a deeper level, you will be able to accept your patients' resistance on a deeper level, and your resistance will dissolve.

Psychodiagnosis of Anxiety: Common Mistakes

Sometimes we make mistakes when assessing anxiety:

- 1) When a patient exhibits some striated muscle tension, therapists sometimes fail to assess all the anxiety pathways. In fact, some patients will experience anxiety in striated and smooth muscles or in all three pathways. Careful assessment of anxiety will help the therapist not work over the patient's threshold of anxiety tolerance.
- 2) When working with a patient who appears limp and calm, therapists sometimes assume the patient has no anxiety. As a result, they miss symptoms of smooth muscle discharge or cognitive perceptual disruption, which are not visible.
- 3) When working with a patient who appears limp and calm, therapists sometimes assume the patient has smooth muscle discharge or cognitive/perceptual disruption. If the therapist avoids focusing on unconscious feeling or relinquishing defenses, no unconscious anxiety will rise.
- 4) When a patient is able to observe her anxiety, some therapists rush ahead without assessing whether the patient can pay attention to and regulate her anxiety. A patient may observe her anxiety but then ignore it, preventing anxiety regulation. Until the patient turns against the defense of ignoring her feelings and anxiety, inviting feeling will fail. A patient cannot face and experience her feelings if she ignores her anxiety and feelings.
- 5) Some therapists pursue feeling when anxiety goes into the smooth muscles or cognitive/perceptual disruption. This results in stomachaches,

headaches, increasing depression, dissociation, and projection. Now the patient suffers from excessive anxiety. *The therapeutic goal is not to face feelings while paralyzed with anxiety, but to experience one's feelings deeply while anxiety goes into the striated muscles.*

Analyzing Your Interventions to Become more Effective

Improve Your Batting Average

You know how batters in baseball have a batting average? It's the percentage of times they hit the ball when they are up to bat. Over time they get better at reacting in time to hit the ball rather than miss it. You can do the same.

Analyze each intervention you do and put it under one of these categories:

1) exploring feeling; 2) regulating anxiety; 3) addressing defense; 4) cognizing. If you are anything like I was initially, you will find that the biggest percentage of your interventions is cognizing. You want the biggest percentage to be exploring feeling. That's your first goal. Once a week, pick a session and see what your percentages are with a patient. Next week, pick the next session with that patient and see if your percentages have risen. When they do, you'll see a wonderful shift in the session. See if you can explore feeling more frequently than cognizing.

Once your percentages have risen, we go to phase two. Analyze each of your interventions and list them under the following categories: 1) exploring feeling; 2) regulating anxiety; 3) regulating anxiety and returning to feeling; 4)

addressing defense; 5) addressing defense and returning to feeling; and 6) cognizing.

Notice a theme here? Now we will measure the degree to which you are maintaining a therapeutic focus. Categories 1,3, and 5 must be far larger than categories 2,4, and 6. Note the proportion this week. Then measure those same categories with the same patient next week. If you can shift these proportions until categories 2, 4, and 6 disappear, you will see a marked improvement in the work, and you will see patient symptoms dropping more rapidly.

Practice Doing the Right Thing in Real Time

How can you help yourself intervene more effectively and quickly in session?

Practice doing it while watching your video. Once you have a sense of what you need to do, start doing it while the video is running. Let the video run. Don't criticize yourself, just say the right things to the video while it runs. Keep intervening while the video runs. This way you'll be doing the right thing, more quickly, in real time with the video. If you tend to get depressed when watching your videos or too self-critical, then supervise yourself this way. No self-criticism for saying wrong things. Just say the right things and let the video run. Just keep intervening while the video runs in real time. This will help build your ability to intervene more quickly and persistently.

Finding the Problem

When you analyze each of your interventions, notice when you are stumped by a defense. Notice what defenses come up most frequently. Those are the ones

blocking the way to feelings. Then go to the skill building exercises and practice the skills for those defenses specifically. In other words, you don't have to do everything. You just need to work on that defense and the skills for addressing it. Then you'll be able to go further. The skill building exercises are at

www.istdpinstitute.com

Watching My Videos is So Painful

First of all, no video ever hurt a therapist. What hurts us is our unreasonable self-criticism. Watching videos is never painful; self-attack is painful. There are several strategies I have mentioned to counter unreasonable self-criticism, but here they are again. If you are too self-critical:

1. Watch the video with the sound off. Right now, words on the video feed your self-attack habit. So, turn the sound off. Now whenever the patient sighs on the video, stop the video, run it back ten seconds, and listen to your intervention. Write it down. Then run the video until the next sigh. Stop the video, rewind ten seconds, play the video, and write down your intervention. Every intervention that caused a sigh was useful. Go through the entire video. Armed with interventions that worked, just use those interventions in the next session. They work.
2. Now play the video, but do not focus on your interventions. Transcribe only the patient's responses. Analyze whether the patient offered feeling, anxiety that is too high or a defense. Then write down how you wish you had responded for each defense.
3. Now play the video and intervene whenever you wish you had and just talk over the video. Do not listen to anything you said, just talk over whatever you said and intervene while watching in the way you wish you had.

If you don't have a supervisor or therapist to help you with this, remind yourself that all learning involves making mistakes. We should make mistakes. It is how we learn. We should make mistakes because we are never perfect. We should make mistakes if we don't understand where the patient needs help. In short, we should make mistakes when we are perpetual learners.

That's why all psychotherapy teaching, supervision, and self-supervision requires self-compassion. We are all mistake makers. We will always be mistake makers because that is what it is to be human. All learning, whether it is in music, sports, or therapy, involves a massive amount of mistake making. Just think! A great baseball player hits the ball only 30% of the time. Attachment research shows that mothers are attuned only about 33% of the time. Just because our superego

thinks we should be perfect doesn't mean that perfection exists on planet earth. It's a myth. Remember, the reason we avoid self-supervision isn't because we will see our mistakes; it's because we will misuse our mistakes for the purpose of self-punishment. We will forget to have compassion for ourselves as flawed human beings, who will always be flawed, real but never ideal. Think of self-supervision as a deeper form of self-acceptance and self-compassion. The more you are willing to face and learn from your mistakes and treat yourself with compassion, think of how much deeper your own acceptance and compassion will be for your patients. After all: they are us---human.